SECTION 2

UTAH HOME AND COMMUNITY - BASED WAIVER SERVICES FOR INDIVIDUALS 65 AND OVER PROVIDER MANUAL

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1 GENERAL POLICY

Under section 1915c of the Social Security Act, a State may request approval through the federal Centers for Medicare and Medicaid Services (CMS) to "waive" certain statutory requirements in order to use Medicaid funds for an array of home and community-based medical assistance services provided to eligible recipients as an alternative to institutional care. The state of Utah has provided Medicaid reimbursed home and community-based waiver services for individuals 65 and older (Aging Waiver) since July 1, 1992. On July 1, 2000 the Division of Health Care Financing received approval from CMS to continue operating the Aging Waiver through June 30, 2005. The approval includes waivers of:

* the "comparability" requirements in subsection 1902(a)(10)(B) of the Social Security Act, and

* the institutional deeming requirements in section 1902(a)(10)(C)(I)(III) of the Social Security Act.

Waiver of Comparability

In contrast to Medicaid State Plan service requirements, under a waiver of comparability, the State is permitted to provide covered waiver services to *only a limited number* of eligible individuals who meet the State's criteria for Medicaid reimbursement in a nursing facility (NF). "Waiver services" need not be comparable in amount, duration, or scope to services covered under the State Plan. However, each year the State must demonstrate that the waiver is a "cost-effective" or a "cost-neutral" alternative to institutional (NF) services. This means that, in the aggregate, the total annual Medicaid expenditures for waiver recipients, including their State Plan services, cannot exceed the estimated Medicaid expenditures had those same recipients received Medicaid-funded NF services.

Waiver of Institutional Deeming Requirements

Under the waiver of institutional deeming requirements the State uses more liberal eligibility income and resource calculations when determining recipients' Medicaid eligibility.

1 - 1 Acronyms and Definitions

For purposes of the Home and Community-Based Waiver for Individuals Age 65 and Older (Aging Waiver), the following acronyms and definitions apply:

AAA	Area Agency on Aging
AGING WAIVER	Medicaid 1915c HCBS Waiver for Individuals Age 65 and Older
CMS	Centers for Medicare and Medicaid Services
DAAS	Division of Aging and Adult Services
DHCF	Division of Health Care Financing
HCBS	Home and Community-Based Services
MAR	Maximum Allowable Rate
NF	Nursing facility

1 - 2 CMS Approved Waiver Implementation Plan

A. The State Implementation Plan for the Aging Waiver approved by CMS serves as the State's authority to provide home and community services to the target group under its Medicaid plan. That document and all attachments constitute the terms and conditions of the program.

B. This manual does not contain the full scope of the Waiver Implementation Plan. To understand the full scope and requirements of the Aging Waiver program, the State Implementation Plan should be referenced.

C. In the event provisions of this manual are found to be in conflict with the State Implementation Plan, the State Implementation Plan will take precedent.

2 SERVICE AVAILABILITY

Home and community-based waiver services are covered benefits only when provided:

1. to an individual determined to meet the eligibility criteria defined in the CMS approved Waiver Implementation Plan;

2. pursuant to a written plan of care.

2 - 1 Eligibility for Waiver Program

A. Home and community-based waiver services are covered benefits only *for a limited number of Medicaid eligibles* for whom there is a reasonable indication that they might need the services provided in a Medicaid-certified NF in the near future unless they receive home and community-based services and for whom, but for the provision of such services, would receive the NF services, the cost of which would be reimbursed under the Medicaid State Plan.

B. In determining whether the applicant has mental or physical conditions that can only be cared for in a nursing facility, or the equivalent care provided through the Aging Waiver, the individual responsible for assessing level-of-care shall document that at least two of the following factors exist:

1. Due to diagnosed medical conditions, the individual requires at least substantial physical assistance with activities of daily living above the level of verbal prompting, supervising, or setting up;

2. The attending physician has determined that the individual's level of dysfunction in orientation to person, place, or time requires nursing facility care; or equivalent care provided through the Aging Waiver; or

3. The medical condition and intensity of services indicate that the care needs of the individual cannot be safely met in a less structured setting, or without the services and supports of the Aging Waiver.

C. An individual will not be enrolled if it is determined during the eligibility assessment process that the health, welfare, and safety of the individual cannot be maintained through the Aging Waiver program.

D. Inpatients of hospitals, nursing facilities, or ICFs/MR are not eligible to receive waiver services (except as specifically permitted for case management discharge planning in the 90-day period before their discharge to the Aging Waiver).

2 - 2 Applicant Freedom of Choice of NF or Aging Waiver

A. Medicaid recipients who meet the eligibility requirements of the Aging Waiver may choose to receive services in a NF or the Aging Waiver if available capacity exists, to address health, welfare, and safety needs.

B. If no available capacity exists in the Aging Waiver, the applicant will be advised in writing that he or she may access services through a NF or may wait for open capacity to develop in the Aging Waiver.

C. If available capacity exists in the Aging Waiver, a pre-enrollment screen of health, welfare, and safety needs will be completed by an Aging Waiver representative. The applicant will be advised of the preliminary needs identified and given the opportunity to choose to receive services to meet the identified needs through a NF or the Aging Waiver. The applicant's choice will be documented in writing, signed by the applicant, and maintained as part of the individual record.

D. Once the applicant has chosen to enroll in the Aging Waiver and the choice has been documented, subsequent review of choice of program will only be required at the time a substantial change in the client's condition results in a change in the written plan of care. It is, however, an Aging Waiver client's option to choose institutional (NF) care at any time and voluntarily disenroll from the Aging Waiver.

2 - 3 Aging Waiver Client Freedom of Choice

A. Upon enrollment in the Aging Waiver, the individual will be given choice among available waiver case management agencies. The applicant's choice will be documented in the case record.

B. Upon completion of a comprehensive needs assessment by the waiver case management agency, the client in participation with the case management agency will participate in the development of the plan of care to address the individual's identified needs.

C. The client will be given choice of services to meet an identified need if more than one cost-effective option exists.

D. The client will be give a choice of available qualified providers of waiver services identified in the plan of care.

E. The waiver case management agency will review the contents of the written plan of care with the client prior to implementation. The written Plan of Care will constitute formal notice of the agency's decision regarding authorized services to be provided to the client and will include notice of the client's right to appeal the decision to the State Medicaid Agency. The client must acknowledge receipt of the notice of decision and right to a fair hearing by signing the Plan of Care.

F. Subsequent revision of the client's Plan of Care as a result of annual re-assessment or significant change in the client's health, welfare, or safety requires proper notice to the client as described in item D above, plus notice that the individual has the right to select to receive services in a Medicaid NF in lieu of continued participation in the waiver.

1. A significant change is defined as a major change in the recipient's status that:

   - is not self-limiting;

   - impacts on more than one area of the recipient's health status; and

   - requires interdisciplinary review and/or revision of the plan of care.

   NOTE A condition is defined as self-limiting when the condition will normally resolve itself without intervention by waiver personnel. Generally, if the condition has not resolved within approximately two weeks, staff should begin a comprehensive reassessment.

2. A reassessment is required if significant change is consistently noted in two or more areas of decline, or two or more areas of improvement.

2 - 4 Termination of Home and Community-Based Waiver Services

The Division of Health Care Financing (DHCF) in partnership with the Division of Aging and Adult Services (DAAS) will compile information on voluntary disenrollments, and routine involuntary disenrollments and will conduct reviews of proposed special circumstance disenrollments from the waiver.

A. Voluntary disenrollments are cases in which clients choose to initiate disenrollment from the waiver. These cases require written notification to the Division of Health Care Financing by the waiver case management agencies within 30 days from date of disenrollment. Documentation will be maintained by the waiver case management agencies detailing the discharge planning activities completed with the waiver client as part of the disenrollment process.

B. Pre-Approved involuntary disenrollments are cases in which clients are involuntarily disenrolled from a home and community based waiver program for any one or more of the specific reasons listed below:

1. Client death;

2. Client no longer meets financial requirement for Medicaid program eligibility;

3. Client has moved out of the State of Utah; or

4. Client whereabouts are unknown.

C. Pre-Approved involuntary disenrollments require written notification to the Division of Health Care Financing by the waiver case management agencies within 30 days from date of disenrollment. No Division of Health Care Financing prior review or approval of the decision to disenroll is required. Documentation will be maintained by the local case management agencies detailing the discharge planning activities completed with the waiver client as part of the disenrollment process.

D. Special circumstance disenrollments are cases that are non-routine in nature and involve circumstances that are specific to the individual involved. Examples of this type of disenrollment include the waiver client no longer meets the corresponding institutional level of care requirements, the client's health and safety needs cannot be met by the current program's services and supports, or the client has demonstrated non-compliance with the agreed upon care plan and is unwilling to negotiate a plan of care that meets minimal safety standards.

E. Special circumstance disenrollments require review and authorization prior to disenrollment to facilitate:

1. Appropriate movement amongst programs;

2. Effective utilization of program potential;

3. Effective discharge and transition planning;

4. Provision of information, affording clients the opportunity to exercise all rights; and

5. Program quality assurance/quality improvement measures.

F. The special circumstance disenrollment review process will consist of the following activities:

1. The waiver case management agency recommending disenrollment will compile information to articulate the disenrollment rationale.

2. The waiver case management agency will then submit the information to the state-level program management staff for their review of the documentation of case management activities and of the disenrollment recommendation.

3. If state-level program management staff concur with the case management recommendation, the case will be forwarded to the DHCF for a final decision.

4. The DHCF will review and assure the available array of Medicaid waiver and non-waiver services, and other available resources have been fully utilized to meet the individual's health and safety needs.

5. The DHCF will facilitate case staffing meetings with appropriate parties, as needed, to complete the review and make an appropriate final decision on the proposed disenrollment.

6. The DHCF final disenrollment decision will be communicated to both the case management agency and the state-level program management staff in writing.

G. If the disenrollment is approved, the waiver case management agency will provide to the individual the required written notification of agency action and right to fair hearing information.

H. The case management agency will initiate discharge planning activities sufficient to assure smooth transition to an alternate Medicaid program or to other services.

2 - 5 Fair Hearings

A. The Division of Health Care Financing provides an individual applying for or receiving waiver services an opportunity for a hearing upon written request, if the individual is:

1. Not given the choice of institutional (NF) care or HCBS waiver services.

2. Denied the waiver provider(s) of choice if more than one provider is available to render the service(s).

3. Denied access to waiver services identified as necessary to prevent institutionalization.

4. Experiences a reduction, suspension, or termination of waiver services identified as necessary to prevent institutionalization.

B. An individual and the individual's legal representative, as applicable, will receive a written Notice of Agency Action from the waiver case manager if the individual is denied a choice of institutional or Aging Waiver program, found ineligible for the waiver program, or denied access to the provider of choice for a covered waiver service. The Notice of Agency Action delineates the individual's right to appeal the decision. The individual is encouraged to utilize an informal dispute resolution process to expedite equitable solutions but may forgo or interrupt the available informal resolution process at any time by completing a request for hearing and directing the request be sent to the Department of Health, Division of Health Care Financing for a formal hearing and determination.

C. An aggrieved individual may request a formal hearing within 30 calendar days from the date written notice is issued or mailed, whichever is later. The Division of Health Care Financing may reinstate services for recipients or suspend any adverse action for providers if the aggrieved person requests a formal hearing not more than ten calendar days after the date of action.

D. The individual is encouraged to utilize an informal dispute resolution process to expedite equitable solutions but may forgo or interrupt the available informal resolution process at any time by completing a request for hearing and directing the request be sent to the Department of Health, Division of Health Care Financing for a formal hearing and determination.

E. An informal dispute resolution process does not alter the requirements of the formal fair hearings process. The individual must still file a request for hearing and a request for continuation of services within the mandatory time frames established by the Division of Health Care Financing. An informal dispute resolution must occur prior to the deadline for filing the request for continuation of service and/or the request for formal hearing, or be conducted concurrent with the formal hearing process.

3 PROVIDER PARTICIPATION

3 - 1 Provider Enrollment

A. Home and community-based waiver services for recipients who are 65 or older are covered benefits only when delivered by a provider enrolled with the State Medicaid Agency to provide the services as part of the Aging Waiver. In addition to a Medicaid provider agreement, all providers of waiver services must also have a current contract with the local Area Agency on Aging responsible for administering the day to day operations of the waiver program.

B. Any willing provider that meets the qualifications defined in the Aging Waiver Implementation Plan, Appendix B-2, may enroll at any time to provide an Aging Waiver service by contacting the specific Area Agency on Aging responsible for the day to day administration of the waiver in the geographical area the provider desires to serve. The Area Agency on Aging will facilitate completion and submission of the required Medicaid provider application and completion of the required local contract. The provider is only authorized to provide the waiver services specified in Attachment A of the Medicaid provider agreement submitted by the provider.

3 - 2 Provider Reimbursement

A. A unique provider number is issued for each of the waiver case management areas associated with the 11 participating Area Agencies on Aging. A provider that enrolls to provide waiver services in multiple case management areas will receive an equivalent number of Medicaid provider numbers. When submitting claims for reimbursement, the provider must use the proper provider number associated with the case management agency area responsible for the waiver client receiving the services. Claims containing a provider number that is not associated with the proper case management area will be denied.

B. Providers will be reimbursed according to the specified reimbursement rate(s) contained in the negotiated contract with the local Area Agency on Aging responsible for the involved waiver client.

C. Providers may only claim Medicaid reimbursement for services that are ordered by the responsible waiver case management agency. Claims must be consistent with the amount and frequency ordered by the waiver case management agency.

3 - 3 Standards of Service

Providers must adhere to service standards and limitations described in this manual, the terms and conditions of the Medicaid provider agreement, the terms and conditions of the Aging Waiver Implementation Plan, and the terms and conditions contained in the contract withe the local Area Agency on Aging.

3 - 4 Provider Rights to a Fair Hearing

The Department provides hearing rights to providers who have had any adverse action taken by the Utah Department of Health, Division of Health Care Financing, or its administrative contractor for the Aging Waiver, and who submit a written request for a hearing to the agency. Please refer to Utah Department of Health Administrative Hearing Procedures for Medicaid/UMAP Recipients, Applicants, and Providers in Section 1, Chapter 6 - 14, Administrative Review/Fair Hearing. This includes actions of a local Area Agency on Aging or waiver case management agency relating to enrollment as a waiver provider, free choice of available providers by waiver clients, contract reimbursement rates, sanctions or other adverse actions related to provider performance, or improper conduct of the agency in performing delegate waiver responsibilities.

4 PRIOR AUTHORIZATION OF WAIVER SERVICES

Effective July 1, 2004, no prior authorization of waiver covered services by the State Medicaid Agency is required. Provider participation and service delivery will be governed by waiver quality management systems for assuring proper development and implementation of plans of care, assuring waiver services are provided by qualified providers, and assuring financial accountability for funds paid to providers for the waiver program.

5 CASE MANAGEMENT

5 - 1 Case Management Encounters

To better focus primary attention on providing the specific level of case management intervention needed on an individualized basis, as determined during the initial and ongoing comprehensive needs assessment process, the individual service plan will be the vehicle through which the level of assessed need for case management will be detailed in terms of the objectives to be achieved, and the scope, duration, and frequency of intervention to be provided to meet the stated objectives. This approach will also promote case managers having specific information about their expected roles and responsibilities on an individualized waiver client basis. Program performance reviews will assess the accuracy and effectiveness of the link between the determination of need, the service plan, the implementation of case management services, and the ongoing evaluation of progress toward the stated objectives.

5 - 2 MDS-HC Assessment Instrument

The InterRAI MINIMUM DATA SET - HOME CARE (MDS-HC) serves as the standard comprehensive assessment instrument used in the Aging Waiver.

6 SELF-DIRECTED EMPLOYEE MODEL

A. The self-directed employee model requires the waiver client to use a Waiver Personal Services Agent as an integral component of the waiver services to assist with managing the employer-related financial responsibilities associated with the employer-employee relationship. The Waiver Personal Services Agent is a person or organization that assists waiver clients and their representatives, when appropriate, in performing a number of employer-related tasks, without the clients being considered the common law employers of the service providers. Tasks performed by the Waiver Personal Services Agent include documenting service provider's qualifications, collecting service provider time records, preparing payroll for clients' service providers, and withholding, filing, and depositing federal, state, and local employment taxes.

B. Client employed service providers complete a time sheet for work performed. The client confirms the accuracy of the time sheet, signs it, and forwards it to the Waiver Personal Services Agent for processing. The Waiver Personal Services Agent files a claim for reimbursement through the Medicaid MMIS system and upon receipt of payment, completes the employer-related responsibilities, deducts the established administrative fee, and forwards payment directly to the service provider for the services documented on the time sheet.

7 WAIVER COVERED SERVICES RATE SETTING METHODOLOGY

A. The Department of Human Services (DHS) has entered into an administrative agreement with the Department of Health, Division of Health Care Financing (DHCF) to set 1915c HCBS waiver rates for waiver covered services. The DHS rate-setting process is designed to comply with requirements under the 1915c HCBS Waiver program and other applicable Medicaid rules. There are four principal methods used in setting the DHS Maximum Allowable Rate (MAR) level. Each method is designed to determine a fair market rate. The four principle methods are: 1) existing market survey or cost survey of current providers, 2) component cost analysis, 3) comparative analysis, and 4) community price survey.

B. The Case Management covered waiver service provider rate is calculated using the cost survey of current providers methodology in general but includes an added procedure in which each fiscal year the State Medicaid Agency establishes specific cost center parameters to be used in calculating the annual MAR.

C. Annual MAR schedules may be held constant or modified with a Cost of Living Adjustment (COLA) for any or all of the waiver covered services in lieu of completing one of the four principle methods depending on the budget allocation approved by the Utah State Legislature for the applicable fiscal year.

8 USE OF "TN" RURAL ENHANCEMENT MODIFIER

A. The use of the TN rural enhancement modifier is authorized in the Aging Waiver for the purpose of assuring access to waiver covered services in rural areas of the State where waiver service providers are required to travel extended distances to deliver services. The rate enhancement adjusts the per unit rate of reimbursement to account for the additional travel-related expenses not included in the normal rate setting process. For purposes of the rural enhancement rate, rural counties are all counties in Utah except Weber County, Davis County, Salt Lake County, and Utah County.

B. The following limitations are imposed on the use of the rural enhancement:

1. The Aging Waiver case management agency must authorize use of the rural enhancement rate at the time the services are ordered.

2. The location assigned as the provider's normal base of operation must be in a county designated as rural;

3. The location from which the service provider begins the specific trip must be in a county designated as rural;

4. The location where the service is provided to the waiver client must be in a county designated as rural; and

5. The direct distance traveled by the provider from the starting location of the trip to the waiver client must be a minimum of 25 miles with no intervening stops to provide waiver or State plan services to other Medicaid clients. When a single trip involves service encounters for multiple Medicaid clients, each leg of the trip will be treated as an independent trip for purposes of qualifying for the rural enhancement (i.e. each leg must involve a direct travel distance of 25 miles or more).

6. When a single service encounter involves multiple units of the same service, the number of units authorized for the rural enhancement rate is limited to the equivalent of one-hour. All remaining units of service must be billed at the base rate set for the service.

7. When a single service encounter involves multiple services, only one of the services is authorized for the rural enhancement rate.

C. Uniform Authorization of the Rural Enhancement Rate

1. It is the responsibility of the Aging Waiver case management agency to authorize any provider to bill for services using the rural enhancement code modifier. The use of the rural enhancement rate should be applied uniformly across the State according to the following guidelines.

2. If the initial authorization was verbal, the Aging Waiver case management agency will follow up with a written service authorization that includes the authorization for rural enhanced reimbursement and will provide a copy of the written authorization to the person responsible for monitoring Aging Waiver billings.

3. The Aging Waiver case management agency is responsible to monitor the Medicaid billing statements to assure providers are appropriately using the rural enhancement rate. In the event of inappropriate use of the rural enhancement rate, the case management agency will notify the Division of Aging and Adult Services

D. When possible, providers must coordinate service delivery to minimize the use of the TN modifier by combining multiple service encounters in a single trip. Waiver case managers must take into account the opportunity to coordinate service delivery among waiver clients served by a common provider when scheduling services as part of plan of care implementation.

9 CLAIMS AND REIMBURSEMENT

9 - 1 Time Limit to Submit Claims

A. MEDICAID PROVIDERS BILLING UNDER A PROVIDER NUMBER FOR THE 1915(C) HOME AND COMMUNITY-BASED SERVICES WAIVER FOR INDIVIDUALS 65 AND OLDER (THE AGING WAIVER) MUST SUBMIT A CLAIM FOR PAYMENT NO LATER THAN 90 DAYS FROM THE ACTUAL DATE OF SERVICE IN ORDER FOR THE CLAIM TO BE ELIGIBLE FOR PAYMENT. The allowable time frame within which an Aging Waiver claim may be filed is reduced from 12 months to 90 days in order to effectively manage the Aging Waiver's established annual budget allocation, to assure funds available during each fiscal year are properly allocated to eligible Medicaid recipients, and to provide an increased level of quality oversight for the care plan implementation process.

B. THIS CHANGE ONLY AFFECTS CLAIMS FOR THOSE SPECIFIC SERVICES COVERED BY THE HOME AND COMMUNITY-BASED WAIVER PROGRAM AND BILLED UNDER THE PROVIDER NUMBER ASSIGNED FOR THE AGING WAIVER. Claims for State Plan services provided to Medicaid recipients who also participate in the Aging Waiver may be submitted up to 12 months from the date of actual service.

C. In the event a claim that was submitted within the allowable 90-day time frame is denied for another reason (such as an incorrect provider number or procedure code), THE PROVIDER MUST CONTACT THE BUREAU OF MEDICAID OPERATIONS TO RESOLVE THE PROBLEM WITH THE INITIAL CLAIM. FILLING A REPLACEMENT CLAIM AFTER THE 90-DAY DEADLINE WILL CAUSE THE REPLACEMENT CLAIM TO AUTO-DENY.

9 - 2 Calculating Claims Using TN Modifier

When using the TN rural enhancement modifier for a claim, providers should bill the total amount to be reimbursed (base amount and 1.75 increase). The Medicaid MMIS system computes the Maximum Allowable Base Rate in the MMIS system reference file multiplied by 1.75 and compares that number to the actual billed amount. The MMIS system then pays the actual billed amount up to the Maximum Allowable Rate X 1.75.

10 SERVICE PROCEDURE CODES

The procedure codes listed below are covered by Medicaid under the Home and Community-Based Services Waiver for Individuals Age 65 and Older.

AGING WAIVER CODES/RATES Effective: July 1, 2004			
WAIVER SERVICE	**CODE**	**UNIT OF SERVICE**	**MAXIMUM ALLOWABLE RATE**
Adult day care, licensed and exempt	S5102	per day	$37.81
Case management, base	T1016	15 minute	$18.11
Case management, rural enhancement	T1016TN	15 minute	$31.69
Case management assessment, base	T2024	each	$221.84
Case management assessment, rural enhancement	T2024TN	each	$388.22
Chore services, base	S5120	15 minute	$5.40
Chore services, rural enhancement	S5120TN	15 minute	$9.45
Companion Services	S5135	15 minute	$3.50
Companion Services, rural enhancement	S5135TN	15 minute	$6.13
Consumer preparation, personal assistance	S5115	15 minute	$15.00
Consumer preparation, personal assistance, rural enhancement	S5115TN	15 minute	$26.25
Environmental accessibility adaptations	S5165	per service	$1,000.00
Home delivered meals, base	S5170	per meal	$7.20
Home delivered meals, rural enhancement	S5170TN	per meal	$12.60
Homemaker services	S5130	per hour	$23.88
Homemaker services, rural enhancement	S5130TN	per hour	$41.79
Personal assistance service, agency, base	T1019	per hour	$14.00
Personal assistance service, agency, rural enhancement	T1019TN	per hour	$24.50
Personal assistance service, independent contractor	S5125	15 minute	$3.05
Personal emergency response system purchase	S5160	each	$225.91
Personal emergency response system fee	S5161	per month	$38.85
Personal emergency response system installation	S5162	each	$50.00
Personal emergency response system installation, rural enhancement	S5162TN	each	$87.50

Medication reminder service	S5185	per month	$86.00
Respite care, unskilled, base	S5150	per hour	$22.52
Respite care, unskilled, rural enhancement	S5150TN	per hour	$39.41
Respite care, home health aide, base	T1005TE	per hour	$24.96
Respite care, home health aide, rural enhancement	T1005TE, TN	per hour	$43.68
Respite care, nursing facility	H0045	per day	$105.00
Specialized medical equipment/supplies	T2029	each	$322.50
Supportive maintenance, base	T1021	per visit	$33.23
Supportive maintenance, rural enhancement	T1021TN	per visit	$58.15
Non-medical transportation, base	T2003	one way trip	$11.00
Non-medical transportation, rural enhancement	T2003TN	one way trip	$19.25
Non-medical transportation, van, base	T2005	one way trip	$21.00
Non-medical transportation, van, rural enhancement	T2005TN	one way trip	$36.75

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